

August 10, 2006

Mr. Glenn Jennings
Commissioner
Department for Medicaid Services
Sixth Floor
275 East Main Street
Frankfort, Kentucky 40621-0001

Attention: Kevin Skeeters

RE: Kentucky Title XIX State Plan Amendment, Transmittal #06-011

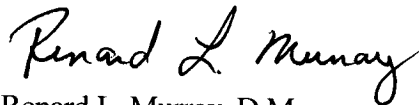
Dear Mr. Jennings:

We have reviewed the proposed amendment to the Kentucky Medicaid State Plan that was submitted under transmittal number 06-011. This amendment authorizes you to submit State Plan Amendments for the Kentucky Department for Medicaid Services.

Based on the information provided, we are pleased to inform you that Medicaid State Plan Amendment 06-011 was approved on August 9, 2006. The effective date for this amendment is July 15, 2006. We are also enclosing the approved HCFA-179 and plan page.

If you have any questions or need any further assistance, please contact Maria Donatto at (404) 562-3697.

Sincerely,



Renard L. Murray, D.M.
Associate Regional Administrator
Division of Medicaid & Children's Health

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FROM: HEALTH CARE FINANCING ADMINISTRATION**TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:

a. FFY 2005 \$0
b. FFY 2006 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 89

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Same

10. SUBJECT OF AMENDMENT:

State Governor's Review

11. GOVERNOR'S REVIEW (Check One):

- ☐
- GOVERNOR'S OFFICE REPORTED NO COMMENT
-
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
-
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Glenn Jennings

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: July 19, 2006

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621**FOR REGIONAL OFFICE USE ONLY**17. DATE RECEIVED:
August 3, 200618. DATE APPROVED:
August 9, 2006**PLAN APPROVED - ONE COPY ATTACHED**19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 15, 2006

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Renard L. Murray, D.M.22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

State: Kentucky

Citation

7.4 State Governor's Review

42 CFR 430.12(b)

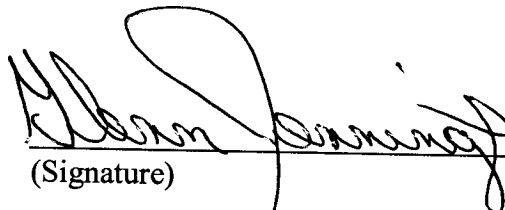
The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

☒ Not Applicable. The Governor-☒ Does not wish to review any plan material.☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services

(Designated Single State Agency)

Date: July 15, 2006
(Signature)

Glenn Jennings, Commissioner
Department for Medicaid Services
(Title)

TN#: 06-011

Supersedes

TN#: 05-003Approval Date: 08/09/06Effective Date: 07/15/06